

**Medical History 1** (Required for Pre-Certification of Services)  
 NYU VEIN CENTER ♦ 530 First Avenue, Suite 6D ♦ New York NY 10016

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

List any allergies \_\_\_\_\_ List current medications: \_\_\_\_\_

**\*\*Your insurance carrier (including Medicare) may require a minimum of at least 3-6 months of “conservative, non-operative treatment” in order for them to pre-approve/make payment for your services. The insurance carriers define “conservative, non-operative treatment” to include: “Mild exercise, periodic leg elevation, weight loss, compressive therapy (stockings), and avoidance of prolonged inactivity”. Please take your time to fill out this questionnaire. \*\***

1. Social History: Smoke?  YES \_\_\_#Packs/day  NO  Alcohol?  YES # per day/week \_\_\_\_\_  NO

2. Have you had any prior treatment for varicose/spider veins?  YES  NO

Describe \_\_\_\_\_ Date (s) of treatment \_\_\_\_\_ Surgery Dates \_\_\_\_\_  
 Type of agent (s) used, if known \_\_\_\_\_

3. Do you have a history of ulcerations, chronic swelling of your legs, or clots? When? \_\_\_\_\_  YES  NO

4. Do you have a family history of varicose/spider veins? If yes, relationship (s) to you \_\_\_\_\_  YES  NO

5. Are you currently, or have been, on any hormone therapy or birth control pills?  YES  NO   
 If yes, please list \_\_\_\_\_

6. Have you had any pregnancies? \_\_\_\_\_ If yes, how many children do you have? \_\_\_\_\_  YES  NO   
 If yes, did your varicose/spider veins increase after your pregnancy?  YES  NO

7. Have you worn support hose? More than 6months? \_\_\_ # months worn \_\_\_ # years worn \_\_\_  YES  NO

8. Are you presently employed? If yes, type of job \_\_\_\_\_  YES  NO

9. Do you sit or stand for long periods of time? Hours per day? Sitting \_\_\_hours Standing \_\_\_hours  YES  NO

10. **\*\*Please describe how your condition/discomfort LIMITS/IMPACTS your daily activity? Frequency/ timing of discomfort/pain?\***

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\_\_\_\_\_ (please use reverse side if necessary)

11. Have you taken any pain medication for you varicose/spider veins? \_\_\_# months \_\_\_#years  YES  NO   
 (Including Aspirin, Tylenol, Motrin IB, Advil, etc.) If yes, please list \_\_\_\_\_

12. Do you elevate your legs to relieve your symptoms? \_\_\_hours/day , # months\_\_\_, # years\_\_\_  YES  NO   
 If yes, does it help?  Temporarily  YES  NO

13. Are you presently on a weight loss/weight management routine? \_\_\_# months  YES  NO

14. Do you exercise?  Mild/Occasional  Regular Regiment  Intense workout # months\_\_\_  YES  NO

**PLEASE CHECK ALL THAT APPLY:**

	RIGHT LEG	LEFT LEG
Edema (swelling)		
Pain (Mild, moderate, severe)		
Tiredness, Throbbing, Achiness		
Ulceration		
Skin color changes		
Spider veins		
Varicose veins		

**\*Patient Signature\*** \_\_\_\_\_ Date \_\_\_\_\_ Nurse Initials \_\_\_\_\_ M.D. Signature \_\_\_\_\_